IHS Partners With Tribal Communities

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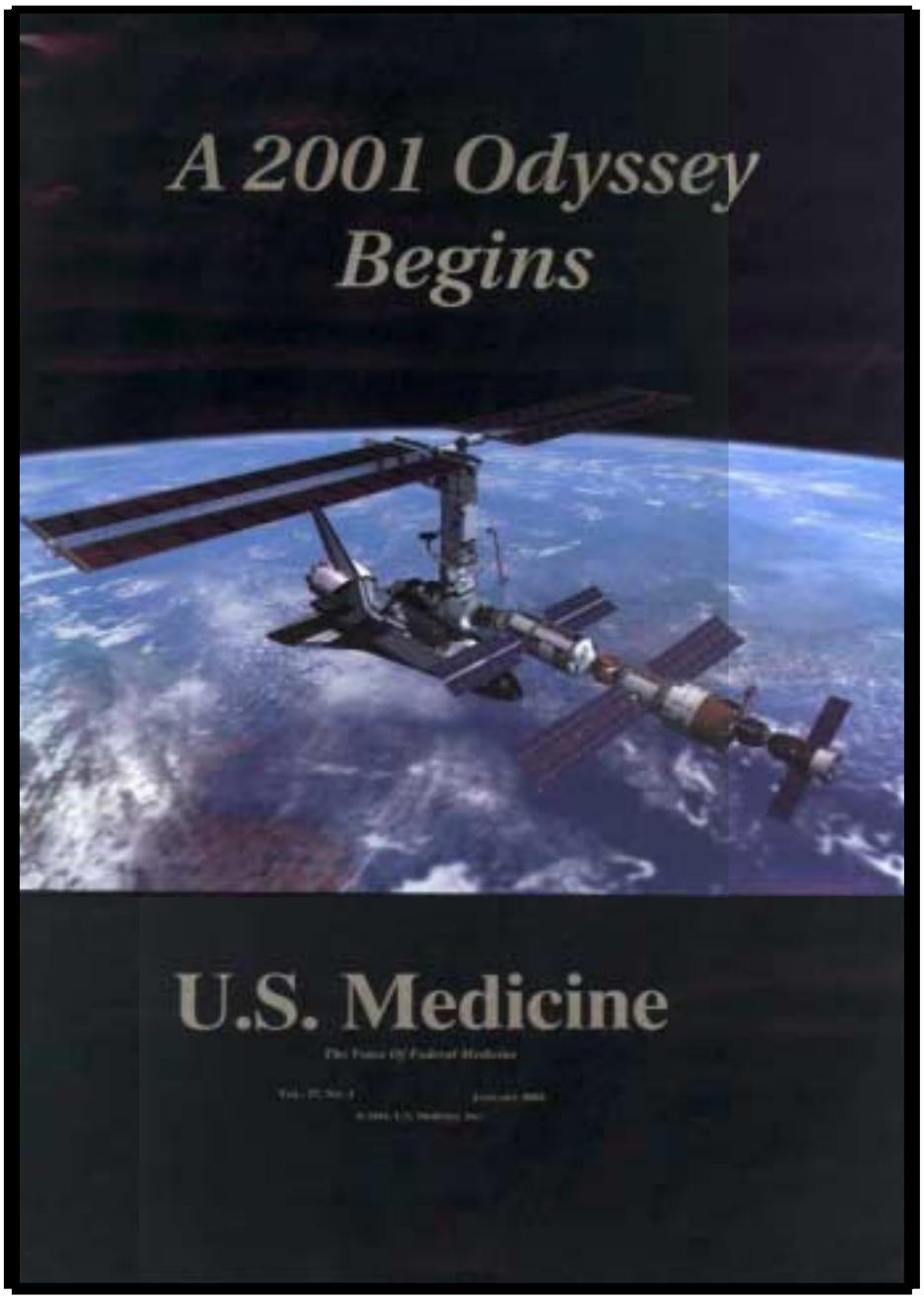

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DESIGN FOR SUCCESS:
Working in Partnership Toward a Healthier Future for American Indians and Alaska Natives

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Since 1994, when I began my tenure as Director of the Indian Health Service (IHS), the agency has experienced many dramatic changes and challenges. As the principal healthcare provider for approximately 1.5 million American Indians and Alaska Natives, the IHS is a unique agency in the Department of Health and Human Services (DHHS), and, indeed, in the entire federal government. The IHS health care system consists of 12 regional (Area) offices and a system of 49 hospitals, 221 health centers, 160 Alaska village clinics, 120 health stations, 32 residential treatment centers, and 34 urban projects. The agency's goal is to ensure that comprehensive, culturally acceptable personal and public health services are available and accessible to the service population. In our provision of health services, we strive to employ a holistic approach to medical treatment, addressing not only the physiological needs of our patients, but also their social, spiritual, and mental health as well. And we do this in concert with the people we proudly serve, through the establishment of a partnership between the American Indian and Alaska Native people and the IHS.

During the last six years, the IHS has made significant progress in several areas that are vital if we are ever to close the gap in health status between American Indians and Alaska Natives and the rest of the U.S. population. These areas include tribal consultation and inclusion, tribal self-governance, collaborations with public and private organizations, administrative restructuring, improved business practices, and establishment of Director's Initiatives on health care.

Consultation and Inclusion

Over the past years, the IHS has moved from a position of control and direction to one of partnership and consultation with the communities it serves. We have established a working partnership that empowers those most knowledgeable of the daily challenges of Indian health care, members of the local health team and communities, to contribute to the decision-making process. I believe the solidifying and strengthening of this partnership represents one of the IHS's greatest achievements over the last few years.

The concept of working in unison with tribal governments to provide community-oriented, culturally sensitive services that best address their needs has been at the core of my vision for the IHS. To this end, the IHS has established and strengthened partnerships with such tribal entities as the National Indian Health Board, Area Indian Health Boards, the National Congress of American Indians, and the National Council on Urban Indian Health, as well as with individual tribal nations.

The inclusion of Indian people in setting policies that affect their health and well-being was given further emphasis and endorsement by the President's Memorandum of April 29, 1994, entitled "Government-to-Government Relationship with Native American Tribal Governments," and the Executive Orders issued on May 19, 1998, and November 6, 2000, both entitled "Consultation and Coordination with Indian Tribal Governments." In these issuances, the President reaffirmed the unique relationship between the U.S. Government and tribal governments, and directed each Executive department and agency to consult with tribal governments before taking actions that affect them.

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The IHS consultation policy has been cited as a model for other agencies to follow. In fact, the IHS assisted DHHS in the development and implementation of the Department's tribal consultation policy. As a result, DHHS became the first cabinet-level entity within the federal government to issue a written policy on tribal consultation. The IHS also worked with DHHS to set up a series of regional meetings in 1995, 1996, and 1999 that provided a forum for Indian leaders and health care professionals to speak directly to Department leadership and help identify opportunities to work with other DHHS agencies. As a result of the Department's consultation policy, DHHS has become the first and only federal Department to hold budget consultation meetings with tribes (the first two annual Department-wide meetings were held on May 4, 1999, and April 10, 2000, with representatives from 35 tribes and tribal organizations). The Department also established a Senior Advisor on Tribal Affairs position in the DHHS Office of Intergovernmental Affairs to serve as the liaison to tribal governments for the Office of the Secretary.

The IHS has worked aggressively to involve tribal and urban Indians in the formulation of policy and development of IHS budget requests. Workgroups have been formed at the regional and national levels on public health support, budget formulation, development of specific health resolutions, and the reauthorization of the Indian Health Care Improvement Act, a legislative cornerstone for Indian health care that provides overall guidance and authority for the IHS programs. The resulting decisions are reflected in Indian health care priorities for the nation.

Tribal Self-Determination

Since 1975, when Congress enacted the Indian Self-Determination and Education Assistance Act, tribes have been able to assume control over the management of their health care services by negotiating contracts with the IHS. The Indian Self-Governance Demonstration Project (SGDP), initially authorized in 1992, greatly expanded this partnership effort by simplifying the self-determination contracting processes and facilitating the assumption of IHS programs by tribal governments and organizations. On August 18, 2000, the President signed the Self-Governance Amendments of 2000, which established a permanent authority for the IHS to enter into self-governance agreements with tribes. It also authorized a study of the feasibility of including other DHHS agencies in the self-governance program.

Almost 44 per cent of the IHS appropriated budget is allocated to tribally managed programs through compacts and contracts

Since 1994, tribal governments have negotiated 47 compacts with the IHS. These compacts represent 265 tribes. Today, almost 44% ($1.06 billion) of the IHS appropriated budget is allocated to tribally managed programs through compacts and contracts. Of the total Indian health system, tribes now manage 13 hospitals, 158 health centers, 160 Alaska village clinics, 76 health stations, and 28 residential treatment centers. An Office of Tribal Self-Governance has been established at IHS Headquarters to support this effort, and policies have been formulated, in consultation with tribes, on contract support costs, tribal base budget amounts, residual shares, user population, and allocation methodologies. A Self-Governance Advisory Committee, composed of nine elected leaders from compacting tribes, has also been established. This committee advises the senior management of the agency and me on the development of self-governance policy and tribal consultation.

The expansion of the SGDP over the last six years and the signing of the legislation to make self-governance permanent have resulted in an increased capacity in Indian communities to directly improve their own health care through the development of local staff and facilities, community involvement in decision-making, and public health interventions.

Public and Private Collaborations

In addition to continuing to develop our partnerships with tribes and American Indian and Alaska Native communities, we have also increased access to resources and expanded our knowledge base through partnerships with external organizations and collaborations with other federal agencies. In the last few years, the IHS has pursued a policy of reaching out to build partnerships within and outside of the federal government with organizations that have the potential to assist in addressing Indian health issues.

The IHS has also strengthened its working relationships within DHHS. Working committees established between the Health Care Financing Administration (HCFA) and the IHS have resulted in greatly increased Medicare and Medicaid reimbursement rates for IHS and tribal facilities. In combination with improved collection methods, this has contributed to significant increases in third-party (private insurance, Medicare, etc.) collections. Between fiscal years 1995 and 1999, collections increased by more than 90%. In April 2000, the IHS and HCFA established a Joint Indian Health Steering Committee to further promote collaborative efforts. Also, I recently signed a memorandum of agreement

with HCFA and the Social Security Administration (SSA) to establish an initiative to actively reach out to elderly American Indians and Alaska Natives to ensure they are aware of the SSA, Medicare, and Medicaid benefits they are entitled to and to assist them in enrolling in these programs, if they are eligible. The Veterans Administration is soon to join this collaborative effort.

The DHHS Centers for Disease Control and Prevention (CDC) and the IHS jointly sponsor the Diabetes Prevention Center in Gallup, New Mexico. The CDC and IHS are also jointly developing an annual work plan to address other Indian health issues, such as cancer, reproductive health, immunizations/vaccines, injury prevention, chronic disease prevention, hepatitis prevention, and nutrient data base analysis. The National Institute of General Medical Sciences within the National Institute of Health (NIH) has also supported various IHS health services programs, including a partnership initiative with the IHS that resulted in $1.5 million in competitive grants to be awarded to establish five American Indian and Alaska Native research centers in fiscal year 2001. Other NIH Centers will join this effort with additional resources. The IHS has also worked with the NIH National Heart, Lung, and Blood Institute to establish a joint initiative called "Strengthening the Heartbeat of American Indian and Alaska Native communities." This initiative focuses on designing culturally appropriate cardiovascular health promotion and disease prevention educational materials.

Other federal partnerships have been established or strengthened over the last six years. As a result of partnership efforts with the DHHS Substance Abuse and Mental Health Services Administration, Indian health programs were provided with access to an additional $25 million in mental health and substance abuse funds. An interagency agreement with the Department of Veterans Affairs (VA) allows IHS facilities to access VA supply centers. The IHS is also working with the DoD and VA on the development of a government computer-based patient record system that would allow the sharing of collective medical expertise and knowledge through computer-based medical consultation, diagnosis, and treatment. Some IHS facilities also have a working arrangement with the VA for the referral of Indian veterans for services at VA hospitals.

The IHS and tribes have also formed alliances with external organizations such as universities, professional associations, and foundations to address Indian health needs. Through these partnership efforts, innovative techniques such as telemedicine are being used to provide cost effective access to specialty care in some remote locations. Linkages with universities and clinics have also resulted in training opportunities for Indian health professionals, such as the Seattle Indian Health Board's residency program, which has graduated six American Indian and Alaska Native family practice residents, to date. A collaborative effort between the IHS, CDC, Department of Transportation, and the United Tribes Technical College has resulted in the establishment of the first associate in applied science degree in the nation in injury prevention. The first class of American Indian and Alaska Native students graduated in May 2000.

The IHS has even built international linkages over the past six years. Since 1995, I have had the honor of representing the United States at the World Health Organization in Geneva. In 1996, I addressed the World Health Organization conference. The governments of Australia, New Zealand, and Canada, and countries in South and Central America have looked to the IHS for its expertise in addressing the health problems of rural and indigenous populations in order to learn about approaches they could apply in their countries. In 2002, the tribes, IHS, and Canadian First Nations will sponsor an international conference entitled "Healing Our Spirit," currently scheduled to be held in Albuquerque, New Mexico.

Administrative Restructuring

In 1995, as part of the decentralization of the Indian health system, the IHS embarked on the first attempt in 40 years to reorganize the overall agency structure. An Indian Health Design Team (IHDT) was formed, consisting of 22 Indian leaders selected by tribes and seven IHS staff. It was the first time that tribal leaders had been involved in this level of agency decision-making. In keeping with the principle of self-determination, the IHDT recommendations focused on the concept that, to the extent possible, management of health services should be at the local level where health services are delivered.

In accordance with the recommendations of the IHDT and as a result of the shifting of many IHS programs and functions to local tribal control through self-determination contracts and compacts, the IHS was downsized and reorganized. The Headquarters administrative structure was simplified by reorganizing nine offices into three, reducing staff by 53%, and eliminating or reassigning functions to the field. Area administrative offices were downsized by 48%, with many of their functions and resources transferred to local service units. The IHS role shifted to one of support and advocacy for the local health services delivery system instead of control over it.

Improved Business Practices

In concert with the efforts to restructure the IHS into a more effective operating system, a workgroup was formed to examine and redesign the many business

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elements required to carry out the IHDT's recommendations. The workgroup was composed of tribal leaders, federal executives, tribal and federal health care professionals, and private sector consultants. This inclusive mix, a reflection of the IHS's consultative and collaborative leadership style, brought a broad spectrum of knowledge and expertise to the formulation of the IHS's first business plan. This strategic plan, first implemented in 1997, is directed at making pragmatic business practices a standard within agency operations. The IHS Business Plan focuses on controlling cost, increasing accountability, managing resources, and generating revenue.

A budget formulation process was also developed that integrated the Government Performance and Results Act requirements and IHS tribal consultation policy. Tribes and urban Indian organizations are now directly involved in the agency budget development process, which attempts to align the budget with strategic objectives and health indicators as defined by the IHS, tribes, and urban Indian organizations. The result has been a better-documented and stronger IHS budget submission that more accurately addresses the health care needs of American Indian and Alaska Native people.

In addition, a Level of Need Funded actuarial study was conducted in consultation with tribes to identify and quantify the high level of unmet direct services health care needs in Indian country. The study determined that the health funding for Indians is 40% below health expenditures in this category for other Americans, and that there is a disparity gap of $1.2 billion between available Indian health funding levels and what is needed to provide current tribal members with personal health services that are equivalent to those provided through a basic mainstream employer-sponsored health benefits package. This, however, does not include needed funding for facilities construction, environmental health, and public health and preventative services.

These efforts to enhance IHS business practices have resulted in dramatic improvements in fiscal accountability and performance in Indian health programs, enabling them to make maximum use of scarce resources.

Director's Initiatives

Since my appointment as Director, I have identified ten initiatives to receive special emphasis and reflect my vision for Indian health. These areas include elder care, women's health, children and adolescents, injury prevention, domestic violence and child abuse prevention, oral health, sanitation facilities, traditional medicine, health care financing, and state health programs.

The goal of the Indian Elder Care Initiative is to support the development of high quality services for Indian elders by acting as a consultation and liaison resource for IHS, tribal, and urban Indian health programs. The core activities of the initiative are referral, technical assistance, education, and advocacy. These activities are accomplished in partnership with a variety of tribal, state, federal, and academic programs.

The Indian Women's Health Initiative focuses on increasing access to preventive services, increasing community education, increasing the number of female providers, and establishing support groups and mentoring programs for young women in their communities. There is emphasis on networking efforts with the DHHS Office on Women's Health, other DHHS agencies, and private organizations.

The Indian Children and Adolescents Initiative addresses the alarming disparity in the health status and general well-being of Indian youth as compared to that of other American youth. This initiative focuses on addressing the physical, mental, social, educational, economic, cultural, and spiritual well-being of Indian youth through a multi-agency approach.

Deaths of children and young adults throughout Indian country are most often the result of traumatic injury. The Injury Prevention Initiative's mission is to decrease the incidence of severe injuries and death, and increase the ability of tribes to address their injury problems. This initiative helps promote capacity building though education, networking, and community assistance.

In order to address the far-reaching and profound effects of violence against women and children on the physical and psychological health of Indian people and communities, I established the Domestic Violence and Child Abuse Prevention Initiative. Through this initiative, the IHS, in partnership with tribes, seeks to improve the health care response to domestic violence by increasing health care providers' capabilities to provide early identification and appropriate, culturally competent responses to victims of domestic violence and child abuse.

The Oral Health Initiative seeks to address the alarming rate of oral disease in the Indian population, which ranges from two to ten times the national rate, by increasing access to essential treatment and preventive oral health services.

The Sanitation Facilities Initiative focuses on expanding sanitation services to Indian homes and communities in order to improve the overall health status. In 1999, the IHS provided new essential sanitation facilities to more than 10,000 homes. The IHS has worked to improve relationships with federal agencies, including the EPA, for the joint funding of sanitation projects.

As a reflection of our belief in a holistic approach to healing, the Traditional Medicine Initiative seeks to foster formal relationships between traditional healers and local IHS service units. This relationship helps incorporate the practice and respect of cultural values, beliefs, and traditional healing practices of Indian people as an integral component of the healing process.

My establishment of the Health Care Financing Initiative was the result of a growing concern about the lack of understanding by federal and state governments about the U.S. Government's obligations to provide health services to federally recognized tribes. The IHS initiated discussions with HCFA to increase understanding about this unique relationship and the need for consultation with tribal governments on actions that affect them.

Closely related to these efforts is the State Health Initiative, which is the focal point for information and legal perspectives on state health care reform and Indian health issues. States have been assuming a larger role in the development and financing of health care programs, as federal oversight and funding is delegated to states as part of health and welfare reform. Working with HCFA, the IHS has provided advice to states concerning the need for tribal consultation on issues such as Medicare and Medicaid and the Children's Health Insurance Program.

Summary

The last six years have brought new opportunities for Indian health care. There have been fundamental changes in the structure, focus, accountability, and effectiveness of the Indian health care delivery system of IHS, tribal, and urban Indian health care programs. The successful decentralizing of the IHS health system and empowerment of tribes and Indian communities to participate in their own healthcare services have shown that a government agency can focus on the customer and, indeed, change its way of doing business. The IHS policies of inclusion, consultation, and collaboration are key to maintaining the gains of the past and addressing the health challenges of the future.

Today, as we look to a new century of unparalleled prosperity in our country, the IHS is committed to eliminating the disparity in health status between American Indian and Alaska Native people and the rest of the nation's population. We will continue to work together in partnership with the people we serve to achieve this goal, and to seek new opportunities to apply this partnership.